Millcreek Township School District
3740 W 26th St Erie, PA 16506
814-835-5300

Student Health History
Completed by Parent/Guardian
Version 20

Student Information:

Child's Full Legal Name: _____
(First/Middle/Last)

Sex: _____ Birth Date: _____

Address: _____

Last School Attended: _____ State: _____ Grade Entering: _____

Student Lives with: Both Parents: _____ Mother: _____ Father: _____ Guardian: _____

Mother's Name: _____ Father's Name: _____Guardian Name: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Family Doctor Name: _____ Phone: _____

Family Dentist Name: _____ Phone: _____

Student Medical/Health History:

Condition:

1. Allergy – Bee Sting Yes _____ No _____ Age: _____
2. Allergy – Food Yes _____ No _____ Age: _____
   If Yes, Identify Food(s) _____
3. Allergy – Other Yes _____ No _____ Age: _____
   If Yes, Identify _____
4. Asthma Yes _____ No _____ Age: _____
5. History of Pneumonia Yes _____ No _____ Age: _____
6. Bed Wetting Yes _____ No _____ Age: _____
7. Diabetes Yes _____ No _____ Age: _____
8. Frequent Colds Yes _____ No _____ Age: _____
9. Frequent Ear Aches/Infections: Yes _____ No _____ Age: _____
10. Heart Condition Yes _____ No _____ Age: _____
    If Yes, Identify _____
11. Kidney Condition Yes _____ No _____ Age: _____
    If Yes, Identify _____
12. Neurological Condition Yes _____ No _____ Age: _____
    If Yes, Identify _____
13. Seizure Disorder Yes _____ No _____ Age: _____
14. History of Hospitalization Yes _____ No _____ Age: _____
    If Yes, provide details _____
15. Other Chronic Illness Yes _____ No _____ Age: _____
    If Yes, provide details_____

(OVER)

MEDICAL HISTORY CONTINUED

16. Is your child's vision impaired? Yes _____ No _____ If Yes, is your child under a doctor's care? Yes _____ No _____
If Yes, explain the condition:
_____

17. Is your child's hearing impaired? Yes _____ No _____ If Yes, is your child under a doctor's care? Yes _____ No _____
If Yes, explain the condition:
_____

18. Does your child have any speech or language issues? Yes _____ No ____ If Yes, is he/she being treated? Yes _____ No _____
If Yes, explain:
_____

19. Does your child have any urinary tract or bowel incontinence problems that might require extra care or preparation in school?
Yes _____ No ____
If Yes, explain: _____

20. Does your child have any other physical illness or impairment that might affect his/her normal participation or progress in a regular school program?
Yes _____ No _____
If Yes, explain: _____

21. Does your child have any mental, emotional, or behavioral issues that might affect his/her normal participation or progress in a regular school program?
Yes _____ No _____
If Yes, explain: _____

22. Does your child have any health problems which might require emergency treatment while at school?
Yes _____ No _____ (seizures, bee-sting or food allergies, bleeding or heart problems)
If Yes, explain: _____

23. Is your child currently under a doctor's care? Yes _____ No _____
If Yes, explain: _____

24. *Are there components of this care that would restrict your child's participation in any physical activity at school?
Yes _____ No _____
If Yes, explain: _____
*If Yes to the above, please submit a statement from your doctor detailing the nature and the duration of the restriction.

25. *Is your child currently taking prescribed medication? Yes _____ No _____
If Yes, please specify name and dosage: _____ _____ _____ _____

*Medication must be administered during school hours? Yes _____ No _____
If Yes, you must read Policy 210 Use of Medications
If Yes, you must complete the Authorization for Medication to be taken during School Hours Form.

26. Describe identifiable birthmark, scar, or other distinguishing features: _____
_____

I grant MTSD medical staff permission to share health information to faculty and staff on a need to know basis?

Yes _____ No _____

Name of Parent, Guardian or Assigned Representative: _____

Date: _____